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St. Bartholomew's Hospital Journal,

OCTOBER, 1901.

"Æquam memento rebus in arduis
Servare mentem."—*Horace,* Book ii, Ode iii.

A Clinical Lecture on Rodent Ulcer.

By H. T. BUTLIN, F.R.C.S., D.C.L., delivered 13th November, 1901.

(Reported by S. R. SCOTT, M.B.Lond.)

GENTLEMEN, I propose to-day to give what may be termed a "house lecture," referring to a case in the Hospital and under treatment, therefore of interest to those who attend my practice in the wards, but not intended for publication.

Here is a man with a "rodent ulcer" below the left eye. It has eaten in much more deeply below the inner canthus, but it extends outwards almost to the margin of the orbit, and the lower lid is already a little everted by the adjacent disease. Where the ulcer is not covered with scab it is nodular and without granulations. In some places the margin of the disease is raised and hard. But there is scarcely anything which would attract attention as new growth.

To compare with it, here is a man with an ulcer of the cheek, which is surrounded with heaped-up tissue, and which is probably due to one of the infective diseases.

When I first came up to the Hospital the teaching as regards rodent ulcer was very different from what it is at the present time. We were still under the influence of the teaching of Sir James Paget.

In the last edition of his book on pathology which he himself edited ('Lectures on Surgical Pathology,' 1853, p. 452), Sir James Paget pressed it very hard indeed that rodent ulcer was not itself truly cancerous, but only allied to cancer.

He distinguished rodent ulcer from the ordinary skin cancer, and says, "I have examined very carefully six of these ulcers, removed by excision, and have never seen in or near them a structure resembling those of epithelial or any other form of cancer. . . . Thus the anatomical distinction between this disease and cancer is evident, and they are equally different in pathology; the rodent ulcer, so far as it has yet been observed, is never attended by similar disease in the lymphatics or any other part, and if completely removed or destroyed it does not recur."

One wonders very much that such an observer should have overlooked the microscopic structure of rodent ulcer so much as not to find *any* structural resemblance to cancer.

But I feel sure he looked to find the characteristic structure of epithelioma. The blocks of cells which are common in rodent cancer I suspect he took to be altered sebaceous or other cutaneous glands.

Had he recognised the cancerous nature of rodent ulcer,

I feel sure he would not have said of this disease that if completely removed or destroyed it would not recur.

For he belonged to the school of humoral pathologists, and believed that cancer was a disease due to a morbid condition in the blood, and appeared in tissues which were predisposed to it.

He was hopeless of any cure of cancer, however large an operation was performed.

When men of such repute as Sir James Paget express an opinion, even though it be founded upon erroneous observation, it carries such weight as to be generally accepted as the truth.

It is only by the repeated efforts of men of less repute that the error is corrected, and the real truth is recognised and made known.

The credit of having discovered and maintained the true nature of rodent ulcer is due to Thiersch ('Der Epithelialkrebs,' 1865), to Charles Moore ('Rodent Cancer,' 1867), and to Collins Warren ('The Anatomy and Development of Rodent Ulcers,' 1872).

At the present time it is so generally admitted that almost the only question which is still disputed is the exact layer of epithelium from which the cancer originates.

Those interested in all that pertains to the pathology of the disease I would refer to a series of papers published in the forty-fifth volume of the 'Pathological Transactions' (1894). There various views on the exact origin of the disease are expressed and justified.

In our own School we believe that rodent ulcer originates in the epithelium of the hair-follicles. How near the truth this may prove to be we cannot at present say.

Even as far back as the time of Sir Benjamin Brodie it was recognised that rodent cancer, as we now call it, may begin as a prominence in the skin with flat glazed surface, having small vessels upon it, and not as an ulcer.

The parts which are most frequently attacked are the face, above the line of the mouth, particularly the region of the nose and eyelids; but the disease may occur on the scalp, neck, and various parts of the body.

For many years this little nodule or plaque may remain about the same size or become a little larger.

Its first appearance is comparatively early in life—from twenty to thirty, or thirty to forty years of age. For five or six years or more it may undergo very little alteration, but sooner or later it becomes irritated in some way, such as by shaving or by the use of the towel, or with the finger-nail the surface may be removed, leaving a sore place which bleeds a little, and on which a dry crust forms.

It may be that in a few days it is again irritated, and the little crust of dried blood is removed, causing it to bleed again.

This may go on for years, until at length an ulcer is established with slightly raised border, and slightly, if ever so slightly, indurated base.

Sir James Paget pointed out that destruction is the main feature of rodent ulcer, and that there is no new growth; but we know now that there is always some new growth, and that the disease may sometimes form a tumour of considerable bulk.

Nowadays it is recognised that the induration around the edges and in the base of the ulcer always contains new growth, which invades all the adjacent tissues, and usually early ulcerates.

All know the terrible damage it may do, but we seldom meet in the present day with the fearful and horrible disfigurements caused by the disease which were to be seen years ago.

The ulcer slowly and continuously enlarges and deepens, destroying true skin, the subcutaneous tissue, the muscles, fasciæ, periosteum, until it reaches the bone itself. Nor is its progress here arrested. The bones of the nose, the orbit, and the cheek are slowly destroyed, and the disease may make its way into the cavities at the base of the skull and into the interior of the skull, and so reach the membranes of the brain.

From the margin of the orbit it may reach to and destroy the eye, and spread across the bridge of the nose to the opposite orbit. From the orbit it may creep down the lachrymal canal and to the interior of the nose, or may break down the bony and cartilaginous barriers, and so enter the nasal cavities.

Every surgeon is familiar with the awful ravages of the advanced disease, the vast chasm which is formed in the very centre of the face, the destruction of the nose and of one or both eyes, in the worst cases.

Everyone must realise the importance of eradicating the disease early before it has attained the very advanced stages.

I feel sure that nine tenths of the failures of operation for rodent ulcer are made because men are afraid of removing a sufficiently wide area of surrounding apparently healthy tissue for fear of the disfigurement which may result. The one fact to be borne in mind is that, if it recurs, it will produce infinitely more disfigurement than even the widest operation for its removal, and the difficulty of dealing with recurrent cancer is far greater, and far less likely to be followed by permanent success, than when the primary disease is treated.

There is one peculiarity which rodent ulcer exhibits, and in which it differs from epithelioma.

It is that the former sometimes skins over, and appears to heal. But I cannot say it ever completely heals in this way. For I have convinced myself, by microscopic examination, that the essential structure of the cancerous disease exists and flourishes beneath the scar just as it does in those parts in which the ulcer has not skinned over.

The new-formed skin by-and-by may break down, and ulcerate again, as if it had never healed; so that the mere

covering of the ulcer with skin is no proof that the ulcer is cured.

Although rodent cancer is said never to affect lymphatic glands, I have seen a case of rodent ulcer in which the lymphatic glands were affected. I did not, however, examine the glands, and cannot say what they contained.

When glandular disease is associated with rodent ulcer, we are in the habit of saying that the rodent cancer has been transformed into epithelioma. I am not at all sure how far we are justified in this opinion.

A patient of mine, an officer of high rank in the Engineers, had a rodent ulcer of the face. Being anxious to gain a certain position, he would not permit himself to be laid up, lest this should spoil his chance. During several years, therefore, he was treated with various caustic applications. Valuable time was lost, and when at last he consented to operation the disease had progressed to a formidable extent, although it still bore all the characters of rodent cancer.

The lymphatic glands beneath the jaw became enlarged, and masses of disease like cords extended from the substance of the cheek to the submaxillary region. He died many months later, but I had no opportunity of examining the glands.

My object in this lecture was not so much to speak of the pathology of rodent cancer as of its treatment.

For a number of years I have been in the habit of freely removing rodent cancer, but occasionally I have destroyed it with a caustic.

Of various caustics I have employed Vienna paste with good success. Vienna paste consists of equal parts of caustic potash and caustic lime, well powdered and mixed, and made into a paste, at the time of using, with absolute alcohol. This paste is applied to the surface of the ulcer and to the skin around for a distance of one third to one half inch outside the area of induration. The skin beyond is protected by the use of strapping. A hole the size of the area to be destroyed is cut in a piece of strapping, which is firmly fixed down in place to protect the surrounding integument from damage.

The paste is kept on for ten minutes or a quarter of an hour, when the whole thickness of the skin and with it the ulcer has usually been completely destroyed.

As this treatment is particularly painful, an injection of morphine ($\frac{1}{6}$ to $\frac{1}{8}$ gr.) is usually given a few minutes before the application is made.

If a second application is needed, the ulcer being deeper, Bougard's paste is more efficient. For the composition of Bougard's paste I would refer you to 'St. Bartholomew's Hospital Reports,' vol. xxiii, 1887, page 57.

An instance in which caustic might be useful would be that of a very aged person, say eighty-five or ninety years old, who had, or whose friends had, a fixed presentiment that a general anæsthetic and the knife would prove fatal to him.

The slough caused by the application takes two or three weeks to separate, and it may be two or three months before the part is healed.

For years I have been in the practice of removing the disease with the knife, and I have made for myself several rules in doing so.

In the first place, I carry the incision one third of an inch, or even half an inch outside the ulcer. In Collins Warren's book referred to, he lays down that the disease only extends one line from the edge of the ulcer. However true this may be of many rodent cancers, it would not be safe to rely too much upon it, and it is far better to cut too wide than too near the indurated edge.

In the second place, I do not perform a plastic operation unless to lessen or avoid some special disfigurement, such as eversion of the lower eyelid or distortion of the nose.

Even in dealing with a rodent cancer on the side of the nose, provided it is not close to the eye, I do not perform a plastic operation.

Some years ago I removed a rodent ulcer from the side of the nose of a particularly handsome young lady, and it was necessary to cut down upon and bare the nasal bone and cartilage. At the time I was uncertain whether or not to do a plastic operation, taking the flap from the cheek. I was afterwards glad I did not do so, for the wound granulated with so little resulting disfigurement, that at the present time all that can be seen is a white and only very slight depression on the side of the nose.

Plastic operations by raising flaps are often disappointing, because the flap is rarely on exactly the same level as the surrounding skin, and the outline of the flap remains always too clearly defined. They answer, however, admirably in preventing eversion of the eyelid and similar troubles.

If the disease invades the orbit, the lachrymal canal, the nasal cavities, or the antrum of Highmore, it is very difficult to follow; hence in these advanced cases one cannot be so sure of success, and recurrence is frequent.

I would again repeat that half-hearted applications of caustics or use of the knife can do no good, and often I feel sure do a great deal of harm. I cannot agree with those who say that the disease usually, sooner or later, recurs. It is my experience to see cases operated upon ten, twelve, and fifteen years ago, with no signs of recurrence.

I am now trying for the first time a new form of treatment—the Röntgen rays. Dr. Hugh Walsham is applying it to the patient you have just seen, and I am watching the experiment with great interest. I am told that the ulcer in this case will probably require twelve to fourteen sittings of ten to fifteen minutes each. I understand that under this treatment even extensive rodent cancers have completely skinned over. If this ulcer

skins over, I shall remove a portion of the subjacent tissue for microscopical examination, to see whether the cancer structure is still present or not. If it is still present I shall have but little confidence in the permanence of the healing.

At present we know really very little about this new treatment. We should like to know if it acts by directly destroying the ulcer, or whether by producing a peripheral neuritis, or in some other way. If by producing a peripheral neuritis, it seems to me conceivable that in a certain number of cases we may have to treat large areas of ulceration, obstinate and very painful, produced by the inflammation of the nerves.

Until we have seen more of this new treatment of rodent cancer, we are unable to say—

1. Whether there is complete destruction of the growth.
2. Whether the scar tissue is free from disease.
3. Whether the disfigurement is decidedly less than that left by a successful operation.
4. Whether the "cures" are as lasting and as permanent as those which result from operations with the knife.

A Historical Review of Changes in Procedure in the Treatment of Operation Wounds at St. Bartholomew's Hospital between 1857 and 1901.

Being the Sessional Opening Address delivered on Thursday, October 10th, 1901,

By A. WILLETT, Esq., F.R.C.S.

MR. PRESIDENT and Members of the Abernethian Society, Ladies and Gentlemen,—When honoured by the request that I would deliver the Inaugural Address of this session's proceedings, I naturally cast about in my mind for a subject fitting the occasion, which whilst to me almost valedictory, is to some of you an inaugural address on the commencement of your careers at St. Bartholomew's Hospital, an institution as venerated as it is ancient; indeed, its antiquity has been happily emphasised by a statement of Dr. Norman Moore's, "That it is quite conceivable, and indeed quite possible, that warriors who fought at the Battle of Hastings in 1066 might, soon after the foundation of this Hospital in 1121, and in their old age, have become inmates, and even have died within the walls of these historic buildings."

To all such, then, as are here for the first time, on behalf of the Abernethian Society I bid a cordial greeting, and I feel sure that as time rolls on you will take a part in upholding and safeguarding its traditions, which are to assist in your own professional education by your own work and in your own ways. I also venture to say that if any of you who have just entered at this Hospital are feeling somewhat forlorn in new surroundings, or somewhat lost in the vastness of this great metropolis, you will soon find that St. Bartholomew's is a little world of its own, and trust me, not a bad little world either; in which you will soon fall into line and take a legitimate pride in being one of her alumni, for I promise you that you may be very happy here, and, as everybody does, grow deeply attached to your *alma mater*.

The subject, then, which I have selected for my address to you this evening is "An Historic Review of Changes in Procedure in the Treatment of Operation Wounds at St. Bartholomew's Hospital between 1857 and 1901." This period of forty-four years comprises my personal recollection of the affairs of this Hospital, and I hope that one aspect of its old-time history may not be regarded as without pleasurable interest. My theme, indeed, will not be that of "temporis laudator acti," but rather of "tempora mutantur, nos et mutamur in illis," and I am confident that when you realise the truly marvellous changes that have taken place in surgery during this period, changes to which no other word than "a revolution" is applicable, you will adopt that motto which has ever animated our profession, "Spero meliora," which means that there is no finality to our knowledge, and that as to-day's position in this respect is better than yesterday's, so to-day's will be and must be bettered by to-morrow's.

It may not, and probably will not, be your lot to witness such a radical change in any branch of medicine as I have witnessed in the treatment of wounds, under that comprehensive term "antiseptic surgery," a method evolved by the genius, amounting to inspiration, of Lord Lister, whose philosophic spirit, perseverance, and indomitable courage carried him through trials and difficulties of all sorts, through opposition, rebuffs, and temporary failures in the success of his anticipated results, to find eventually his views universally acclaimed, and he himself proclaimed as the man who has done more for the protection of the health and the saving of life of his afflicted fellow-creatures than any other man in the history of medicine; for this revolution in surgery has deprived operative surgery of its terrors, and indeed, in many classes of operations, has robbed death of its victims, and yet this change may be stated in few words, which while telling the simple fact, fail to do justice to its magnitude and wide-reaching effects. They are no more and no less than these, viz. the conversion of the normal healing of wounds made by the surgeon at operations from that known as "union by second intention" or union after the consecutive processes of suppuration, granulation, and cicatrisation, with all the attendant dangers under old-time measures of incurring pyæmia and other forms of blood poisoning, into the normal healing by "first intention," or the immediate adhesion of opposed divided surfaces, thereby effectively preventing the attendant dangers just mentioned.

In this respect I shall surprise many of you by the statement that only once before the era of antiseptic surgery did I witness a capital operation wound unite by first intention; it was regarded as a surprise, and no one could understand how it had happened; the case was one of amputation of the thigh for disease of the knee-joint in a delicate girl of about ten. The operation was performed about the year 1856, in the Brighton Hospital, where at the time I was a resident pupil.

I do not wish to mislead you with assuming that no kind of operation wounds healed by "first intention" in the pre-Listerian days, for almost all strictly subcutaneous wounds, *e.g.* tenotomy, punctured wounds, did close at once; so also did many wounds of the face, *e.g.* hare-lip wounds, and even the common scalp wounds in the surgery often healed without trouble, but in all operation wounds there was never anything like certainty in their healing, nor was surprise felt when they suppurated, whilst, as I stated, capital operation wounds invariably suppurated; indeed, as you will learn directly, they were made to. When I come to tell you something of the ways in which operative surgery was conducted and of the surroundings of patients, you will be astounded by the statement that, as regards results to life, such operations as in those days were considered necessary and justifiable were attended by very fair success. This statement I will establish by a brief reference to figures, which are instructive, of the operative surgery of the early years of the period under consideration. I have taken them from the Surgical Statistical Report for 1863, being the first year in which returns were compiled. By way of contrast I give corresponding figures from the Report for 1899, with some additional figures from this latter year's Report enumerating operations *now* fairly common, but which in 1863 were either unknown procedures, or if known, were very generally held to be unjustifiable.

In the first place let me state the total number of the operations performed in the two years. In 1863 417 patients were submitted to operation with a mortality of 64, whilst in 1899 the operations amounted to 2446 with 175 deaths. Thus the number of operations have increased six-fold since 1863, whilst the deaths are three times as many. The number of deaths after operation at the present time at first blush seems to give cause for surprise, but this feeling is at

once removed by the fact that no less than 116 of these deaths followed upon classes of operations the propriety of which was unrecognised in 1863, and that the true mortality for comparison is 59 deaths in 1899 against 64 in 1863. The 116 deaths which I have deducted comprise 9 after operations on the larynx, 12 after tracheotomy for diphtheria, 7 after resection of part of a rib for empyema, 14 after trephining for mastoid disease, 6 for operations on the kidney, 48 after abdominal section in cases of obstruction and other diseases of the intestines, 16 acute appendix operations, and four unclassed. Thus it is evident that in these 116 deaths operations were undertaken for diseases which would inevitably have proved fatal if left to take their course, and in which all that can be urged is that operation failed to save life.

The character and scope of operative surgery since the Listerian era, and the extent which it has now reached, is abundantly shown by the mere statement that in the return for 1863 one looks in vain for information upon such "every-day" operations as for instance:

Removal of varicose veins, whilst in 1899 there were 79 operations without a death. Likewise—

Radical cure of hernia in 1899 there were 180 operations without a death.

Abdominal section in 1899 there were 157 operations with 78 deaths.

Appendix abscess in 1899 there were 80 operations with 16 deaths.

Appendisectomy in 1899 there were 36 operations without a death.

Operations on the kidney in 1899 there were 41 operations with 7 deaths.

Resection of rib in empyema in 1899 there were 43 operations with 7 deaths.

Osteotomy and osteoclasia in 1899 there were 33 operations without a death.

Many other operations, such as suture of divided nerves and tendons, on the nerves and air-passages, wiring patella for fractures, inguinal colotomy, excision of rectum, hysterectomy, and the various abdominal operations, *e.g.* in the gall-bladder. Lastly, I must not omit adenoids, which, as you know, are far more frequently operated upon in the special patient department for diseases of the throat, where, I am told, there are often to the tune of ten or twelve operations in an afternoon. These figures may seem rather a digression from my subject, but I felt they would serve to emphasise the wholly extraordinary change that has taken place in operative surgery in the last forty years more eloquently than any general statement I could offer.

Now for a few comparative figures in classes of operation that fairly admit of comparison—

	1863.	D.	1899.	D.
Capital amputations	31	10	34	4
Herniotomy for strangulation	31	19	44	6
Cancer of the breast	15	2	91	3
Non-malignant tumour of the breast	3	1	35	—
Cancer of the tongue	2	—	16	2
Other malignant tumours	11	—	41	—
Other non-malignant tumours	37	1	110	—
Excision of joints—hip	—	—	5	—
„ knee	1	—	12	—
„ shoulder	—	—	1	—
„ wrist	—	—	1	—
Excision of bones	9	2	29	2
Ovariotomy	1	1	62	10

Before enlarging on the special subject of my address, and in order to render you in some measure informed on old-time surgical practice in this hospital, I will place before you a brief survey of how matters were conducted when I was a dresser.

Each surgeon had a special "box carrier" attached to him, whose duty it was to attend his surgeon on his rounds of the wards, always carrying the well-known square-shaped box of instruments in ordinary use, and also boxes of various kinds of catheters. When any instrument was required, the surgeon called out, "Box carrier, give me a scalpel," and the like. This individual, with dirty hands, would grope about for the required instrument, ligature, etc. Moreover he was charged with the custody and cleaning of all the instruments.

Systematic case-taking by dressers was not practised in the surgical wards until 1880, although the clinical clerks in the medical wards had been trained in regular note-taking for fully thirty years previously, and the only board at the head of each patient's bed was the pale-tinted blue medicine and diet paper. Again I may mention that the clinical thermometer was not introduced until about the year 1863. At first and for some years it was hardly anything more than a toy, physicians and surgeons alike relying entirely upon the character of the pulse, and the sensation of heat of the patient's hands or body as complete indication of the amount of febrile disturbance. Only after repeated convincing evidence of the unreliability of such tests, by proofs afforded by the thermometer, was this infallible test of the body temperature taken into favour, until gradually it has come to be regarded as a sign more important than any other. Temperature charts have not, I think, been in use in the surgical wards for more than twenty years.

A few words on the dieting of patients and the drugs given. Every patient on full diet had one pint of table beer given him or her at dinner. This beer, commonly called "swipes," was not greatly appreciated, and if patients were well conducted the sister would often ask to have stout ordered in its place. At the time I am speaking of the medical treatment of acute diseases had just been revolutionised. The antiphlogistic regimen, consisting of "blood-letting," blistering, salivating with mercury, purging, and a diet of water gruel had died out, and the pendulum had swung full in the opposite direction, and the "support the strength" school had full sway. Mr. Skey was its apostle at this hospital; he was wont to inculcate that bark and opium were the only drugs of any value, and that the low vitality of his patients necessitated wine and brandy in large quantities; but speaking generally drugs were not used much more in the surgical wards than now. Three grains of potassium iodide was regarded as a full dose and one never saw this drug exhibited in doses of twenty to thirty, or sometimes even of sixty to ninety grains, as we now not infrequently employ.

There were but three surgeons until 1854, and even after that date, when there were four, each surgeon had a great many more beds than the surgeons of to-day; for instance the late Sir William Lawrence had the whole of Rahere as his men's accident ward, and the whole of Henry for ordinary surgical diseases for men. The front ward of "Lawrence," at that time called "Queen," was his women's accident ward, whilst he had the whole of President for women in addition. Then he was entitled to three or four beds in Lucas and two or three in Abernethy, for these two wards, being close to the operating theatre, it was thought right that each surgeon should have beds in them for emergency operations, strangulated hernia and the like. But besides all these beds, Sir William Lawrence, and equally each of the four surgeons, had thirteen beds in Magdalen and six or seven in Lazarus. Magdalen formed the wards now called Charity and Paget; whilst Lazarus has now become "Coborn." There was no thought then of separating cases which we now term "septic" from the other patients, indeed it was no unusual circumstance, and gave rise to no comment, to find in one of the ordinary surgical wards a patient with erysipelas in a bed next to one who had undergone amputation of the thigh, and then next to the latter a patient with pyæmia after operation.

The nursing arrangements were primitive! The staff of each ward comprised a sister and three nurses. The sister in some instances had been a nurse, and being found capable and intelligent had been most properly promoted, for at least she had had some years' experience of hospital life, and often such proved admirable sisters. But other sisters had come absolutely fresh to hospital life, owing their appointment to interest, and not infrequently because they were relations of existing sisters, whilst, if tradition is correct, one sister came straight from being a housekeeper to an alderman, whilst another, a Sister Hope, an historical yet excellent sister, had previously, as a patient, had her thigh amputated in the hospital. The nurses were "*inter se*" of equal rank, sharing the entire work of the ward between them, and were on night duty one night in three; they came to the service of the hospital without previous experience, and often remained until worn out; they retired on a pension, and they were mostly of Dickens' Mrs. Gamp type.

In the year 1857 the senior surgeons were all near the end of their tether, for they and two of the assistant surgeons resigned office in the course of the next ten years—Sir William Lawrence in 1865, at the age of eighty-two, whilst Mr. Skey, who was the first surgeon to come under the age-retirement rule of the hospital, and Mr. Wormald, did not attain to the position of full surgeon until they were approaching sixty. I mention these facts, because I think they tend to show that from men so senior it was scarcely to be expected that they would start any investigation into the healing of wounds. Indeed, when asked about changes in hospital life, they told of the improvements they had witnessed and taken their part in bringing about since their young day, such as the practical abolition of hospital gangrene and of sloughing phagedæna as epidemic scourges in surgical wards.

Lord Lister first expounded his views in 1872. He coined the term

antiseptic surgery—on which I shall have something to tell you later—to express his views on the line surgeons ought to follow; hence you will understand that in taking you back to old-time surgery I am telling you of a state of things when our present-day knowledge was undreamt of.

Having in some measure prepared you by reference to the condition of things prevalent nearly fifty years ago, I propose to go now a little more into detail into the actual procedure at operations. As an example let me assume that a patient with destructive disease of the knee-joint had been admitted into the hospital, and that amputation had been decided upon. The preliminary preparations comprised merely a warm bath, if the patient's local condition permitted, or, if not, then such washing of the patient's body-surface as was practicable—locally only shaving the thigh was thought requisite—and in this condition, with just whatever dressing on as had been used—frequently a poultice or water dressing over the knee—the patient would be brought into the theatre and be placed on the amputating table to be put to sleep. The anæsthetic used in those days was chloroform. I should have added that, as at present, patients were kept without food for some hours, also that the time would be Saturday afternoon, which was the only operating day in the week, the surgeons operating according to seniority, and rarely would any surgeon have more than one operation. It was the etiquette of the period for the entire surgical staff to be present throughout operations. Chloroform was administered practically, as at present, on lint, or by some on a towel folded into a cone. There was but a single anæsthetist; the two first appointed were assistant physicians to the hospitals, and wardens of the college, the late Drs. Black and Martin.

The instruments required for the operation would be taken out of their respective cases or drawers, laid on a tray, covered by a towel, and taken straight into the theatre for use.

For ligatures and sutures plain dry white silk on reels, in various sizes, and just as they were received from the manufactory, were used, portions being cut off in lengths by the house surgeon, and needles threaded before operation. As to sponges, the sisters of Lucas and Abernethy Wards attended all operations. It is quite a modern innovation for the sister of the ward to accompany her own patients to the theatre. The two sisters mentioned had each her bag of sponges, which she would turn out into a basin of water ready for service, and they would be used at all operations indiscriminately, and after operations were over the sponges would be cleaned by repeated washing in hot water, dried, and replaced in the bag, ready for use when wanted. Comment on the abominations, as we should now regard these sponges, is surely superfluous.

Now I turn to the surgeon and his staff, viz. his assistant surgeon, house surgeon, and dressers. On entering the operating theatre the surgeon and assistant surgeon went straight to the first cupboard on the right, under the raised area for students, which is still existing. From pegs in this cupboard they took down and put on their operating coats, closely buttoning up to protect shirt, collars, and under garments. I must give you some description of these operating coats, and candidly, I feel you will have much difficulty in admitting it to be quite authentic, but I vouch for its strict accuracy.

To begin with, the coat itself, usually an old frock coat, had always seen good service, and presented a very delapidated appearance; nevertheless as an operating coat it would last the surgeon for many a year, possibly even during his hospital career, and for all this time these coats were seldom brushed and never cleaned, becoming, of course, thickly begrimed with old blood-stains, pus, and masses of all kinds. One would have expected these coats to become offensive, but I am bound to state such was not the case. This coat cupboard always smelt wholesome. I verily believe that these gory coats—I speak from personal experience,—marking the operator, and presenting evidence of having seen much hospital service, were a source of legitimate pride and satisfaction to the wearer, for they were always very reluctantly discarded at the request of the then Sister Abernethy for a newer one; "No! no! Sister" the surgeon would reply, "This coat will last me a good while longer."

These operating coats were worn by all the surgical staff, until at least the year 1880, when gradually, one by one, the surgeons, awakening to the fact what filthily unsanitary things they were wearing, abandoned them for the modern washing aprons or gowns.

My recollection happily does not go back to the days before chloroform, so, let us assume our patient to be under its influence, and the surgeon prepared to commence the operation, the limb being exposed, and the patient placed in a convenient position with a tourniquet over the femoral artery. At this point many of my hearers will be wondering why I have omitted to mention such necessary steps as washing hands, cleansing the skin of the patient's thigh; but the fact is that neither the surgeon nor any of his assistants would, as a matter of routine, have washed their hands; and did not do so unless obviously dirty, or unless they had just come straight from the post-mortem or dissecting-rooms.

The merely manipulative steps of the operation were much the same then as now, except that in amputation cases either the "double flap by transfixion," or the "circular" operations were by preference adopted. We may then assume the limb to be removed, and the stage of securing the bleeding vessels to commence. The divided arteries would be seized with Assilini's catch-forceps, for "pressure forceps" were not introduced until the "seventies." All vessels, as taken up, would be tied with the plain silk ligatures I have already described, and *one* end cut off, while the other would be brought out of the wounds, so that in the end there might be from one dozen to two dozen ligatures brought out through the wound, where they remained until they "dropped," as the phrase went, meaning that each ligature, having ulcerated through the vessel, was lying loose and could now be drawn out. Curiously, an entirely false conclusion was prevalent as to the necessary changes in the process of separation of a ligature, and this in one operation, viz. in ovariotomy, delayed for years the adoption of intra-peritoneal ligature of the pedicle. For the teaching was that everything on the distal side of a ligature sloughed; hence to ligature the pedicle in ovariotomy was held to be certainly followed by the death of the patient, in consequence of mortification of the end of the pedicle; thus for fifteen years or so the pedicle in ovariotomy was always either brought outside the abdominal wound and secured with a "clamp," or divided by a cautery iron to prevent bleeding, and then dropt back.

After this digression I must take you back to the final closing of our amputation stump. When bleeding had been arrested and the tourniquet removed, the wound, after being sponged over with plain warm water, would be sewn up with interrupted silk sutures, the long end of the ligatures being brought out and arranged between the sutures. The immediate covering dressing varied, but at the date under consideration "water dressing" was in common use, *i. e.* three or four layers of wet lint, over which came a layer of oiled silk or gutta-percha tissue, this again covered with a layer of cotton wool and secured by a bandage. The patient was now returned to the ward.

You will, I imagine, be in anxious expectation as to the fate of this patient; but as the figures I have quoted show, a large majority of even major operations recovered, and the after-progress would be much after this wise. The first dressing would be made at the end of two days as a rule, a feverish condition of the patient being the indication, and great was the satisfaction of the surgeon if fairly active manifestations of local inflammation were present, whilst should even a few drops of pus be seen issuing between the edges his satisfaction was all the greater; in short, union by second intention was expected, indeed one may say it was pre-ordained, although unwittingly. The signs of its onset were welcomed as evidence that the early dangers of "blood poisoning" were passed. Well then, after pronouncing his content with the patient's condition, the surgeon would order a suture here and there to be removed, and the stump to be enveloped in a linseed or bread poultice to promote suppuration. Henceforth poultices would be changed three times a day, and continued for three or four weeks in cases doing well, but often for two or three months in others; the remaining sutures being cut day by day, two or three at a time. Much attention was necessary to retain the opposing edges of the stump in apposition. The dresser would have day by day to adjust long strips of plaster for this purpose. Poultices were in constant use, and the number made daily in a ward would astonish you. Thirty would be no unusual amount, and I may remark, by the way, that poultice-making was brought to a fine art, for it had to be of course hot, but also so thoroughly mixed, and of such precise consistency, that the mass could be spread out over a layer of tow, and yet not be so thin as to pass or be pressed through the tow; moreover there can be no question that to patient's sensations a well-made poultice was most comforting.

In most operation wounds there was more or less sloughing of subcutaneous tissue, and not infrequently of some portion of skin. Poulticing went on until all sloughs had been cast off and granulations were seen cropping up, then, the acuter manifestations of inflammation having passed away, resin ointment on lint strapping and bandage would be substituted, and if all went well the patient's convalescence would be established in about six weeks to two months after operation.

Round about the tenth day was regarded quite superstitiously, and yet in point of fact quite rightly, as the critical time with a patient. The surgeon would often inquire of the house surgeon or dresser if the tenth day had passed, and experienced sisters would reply to an expression— how well such a patient was doing, "Ah wait, it does not do to crow until after the tenth day." It was certainly most remarkable how, when a patient after operation was apparently progressing well, suddenly, and without warning he would be seized with a severe rigor, followed by profuse sweating; then he would sleep, and on awaking the patient would declare he was quite well, but a peculiar sunken expression and rapid feeble pulse, told the experienced eye of a surgeon or a sister that he was the victim of acute pyæmia. In less than forty-eight hours probably another rigor came on, and now, perhaps, he would complain of pain in some joint, which would be found hot, swollen, and tender, with at first a bright vivid blush, passing into a dull red, and probably he would begin to cough, and then quick shallow respirations, with sharp pleuritic pain, would usher in pyæmic pleuro-pneumonia. Rigors would return with greater frequency, the patient commonly dying about the sixth day. Well-nigh every patient with pulmonary symptoms died, but if the pyæmic infection was confined to joints or areolar tissue, the disease tended to become chronic, and a small proportion struggled through their pyæmia. It is noteworthy that not every joint attacked required to have pus evacuated, for occasionally joints were successively attacked, as in rheumatic fever, and pus would only be let out from one or two. Pyæmia such as I have described was more frequent than acute septicæmia, and moreover the fatal pyæmias after operation of these days were different to the occasional pyæmia seen in admitted patients. Pyæmia occurred much more commonly in amputations and operations on bones, *e. g.* resection of joints, than after removal of tumours; on the other hand, erysipelas occurred most frequently in the latter class of operation.

For another matter in these pyæmic cases one lesion was found with remarkable constancy, viz.:—a breaking-down thrombus in the main vein of the limb.

Secondary hæmorrhage before the advent of Lord Lister's teaching was as a complication of operative surgery of far too frequent occurrence, particularly after those operations in which large arteries had been tied, both after amputation and in continuity. This mishap is not to be wondered at, seeing that the silk ligature had to cause ulceration through all the arterial coats before its separation or "fall" took place, this process moreover going on in freely suppurating wounds.

Pyæmia and erysipelas were practically endemic in the surgical wards, for when either of these affections attacked a patient his continued presence in the ward was not objected to, neither was it conceived that he would be a source of special risk to other patients, the view held being apparently that, as patients had the benefit of the hospital, so they must equally take whatever risks came in their way.

For some years before 1872 an unrest and a feeling of dissatisfaction at the evils attendant upon operation cases became very general amongst British surgeons, and in this and other hospitals various experimental changes in the after-treatment of wounds were tried; for instance, at one time, in Sir James Paget's wards, all amputation wounds were left unsutured, and uncovered by any dressing, the stump being merely slung, and a dish being put under it to catch discharge. No improvement in results following, then irrigation of wounds was tried; but when Chassaignac's invention of the rubber drainage-tube was announced, wounds were closed and drained; under this plan better results were attained.

But the first serious attempt to direct the attention of surgeons to the evils, and the peril to other patients of the then existing state of hospital wards was made by Professor Simpson in 1869. He published an article on "Hospitalism." He condemned hospitals as charnel-houses, as death-traps; he maintained that surgical wards reeked with pestilential emanations which infected patient after patient through the agency of their wounds. We now recognise how true and right he was in both respects. The professional conscience was deeply stirred by this attack, for it was asserted that a patient's chances of recovery from an operation were infinitely greater in his home, especially if his home was in the country, than in a hospital ward. Simpson held that "union by first intention" was practically, as well as theoretically, attainable, and as a step in that direction he advocated the practice of acupressure as a method for arresting hæmorrhage from arteries cut in operations, thereby doing away altogether with silk ligatures, the evils of which, as then used, were evident to many. Acupressure, however, did not prove convenient, and it was superseded by "torsion."

The late Mr. Callender employed both, and besides for years in dressing he would not allow a wound to be touched with anything but a camel-hair brush kept in a tube of carbolic oil in the medicine rack at the head of each patient's bed. Again improved results followed, but no certainty of primary union was attained in his practice.

My record of events brings me to the era of Lord Lister's discoveries. To formulate his position he asked this question: "Why, if a healthy man sustains a simple fracture of the leg, does he invariably recover without any local complications, such as suppuration, or any general disturbance of his health, as a pyrexia, whilst if the fracture be compound these complications almost as invariably occur, and as their result he may often lose his limb, whilst his life even is put in great jeopardy? And again, "Why, in like manner, do subcutaneous operations for the most part heal without complication, whilst, in open wounds, suppuration always occurs, and erysipelas and pyæmia scourge our wards?" What is the cause of these differences? And if we answer the presence of air in the wounded tissues, again he asked, "What is there in the air that should excite the process of suppuration, and thus cause union by secondary intention?" If the reply be again impurities always present in the air, intensified in large towns, and rendered infinitely more harmful where wounded are congregated in a hospital surgical ward, "Why," he asked, finally, "cannot these admitted baneful influences be met and overcome? This was the problem Lord Lister set himself to work out, and the system and practice of antiseptic surgery to-day is the result. It is not, however, within the scope of my address to present a review of Lord Lister's work, extending over very many years in slowly elaborating the practical measures required to bring the antiseptic system to its present state of perfection. Suffice it to say that, despite of unexpected mishaps, of partial failures, and of ungenerous criticism, he never lost faith in the doctrine he had proclaimed; but steadfastly keeping in view the object he had set himself to accomplish, he pondered over the causes of partial non-success, and he experimented again and again, and finally elaborated his process, until at length the whole world has adopted the principles he enunciated, and has profited by the process he has brought to such perfection.

My task is to record the alterations in procedure at this hospital, and these will be conveniently grouped as follows.

(1) The preparatory measures adopted before operation, which comprise (*a*) the patient; (*b*) the surgeons and those assisting at operations; (*c*) the instruments and appliances to be used at operations.
(2) The alterations made in the conduct of an operation.
(3) Those made in the after-treatment of the patient, and in aid of union of his wound by first intention.

The ideal state of things is such perfect cleanliness of persons, viz.: the parts about the seat of operation in the patient, of the hands of those who take any part in the operation, whether of those who will come into actual contact with the wounds or of nurses who handle sponges, basins, dressings, that no one of these persons can infect a patient's wound.

Then, again, such perfect purity in all materials, including under this term instruments, ligatures, sutures, sponges and dressings, is required that they shall be absolutely free from any substances which could infect the wound; and lastly, after operation to protect the wound from becoming infected from outside sources. The difficulty, however, lies not in saying what comprises the ideal condition, but in working up to it, *i. e.* in devising measures which shall be capable of ready application, and stand the test of every-day work.

As regards the preparatory measures, bearing in mind what has just been stated, I resume the narration of events. Many changes came at once; thorough and systematic washing of hands and nails in all those in any way engaged at the operation, thorough cleansing of the patient's skin and of hair at the site of operation became matters of routine. Sponges for a time went greatly out of use, so general was the belief that their indiscriminate use in operations made them a dangerous source of infection, whilst, for the time, no reliable plan of making them surgically clean had been worked out. When required in abdominal operations, entirely new sponges, freed, of course, from all coarse sand, etc., and which had then for many days been kept in carbolic lotion, 1 in 20, would be used, but never used a second time. In the place of sponges cotton-wool tabbs were much used in ordinary operations; they could be boiled and then put into carbolic lotion. They are very fairly efficient substitutes, and are destroyed after use. To-day the difficulties attend-

ing the thorough disinfection and cleaning of sponges has been overcome, and they are in general use again. As I have previously stated, the surgeons' operating coats gradually went out of use, and some sort of washable linen sterilised apron or gown took their place.

Silk soaked in strong carbolic solution, or prepared catgut kept in carbolic oil were at first recommended for ligatures, both ends being cut short. But some samples of catgut occasionally turning out to be septic, and this, taken in conjunction with the facts that catgut cannot be sterilised by boiling, and that to make it aseptic at present by chemical reagents is, to say the least, a prolonged and difficult matter, has led to the nearly total abandonment of catgut for silk, which, as this latter material bears boiling once well, and will keep in one-twentieth solution of carbolic for a week or two, has come into very general use. The only objection to silk is the occasional occurrence of suture abscess, indicating, it must be admitted, that either the silk had not been rendered sterile, or that it had become infected in the wound. Kangaroo-tail tendon has been, and is, much employed for ligatures in special cases, such, for instance, as ligature of a main artery in continuity. Silver wire was for a long time employed as a material for sutures. It was supplanted by catgut on the ground that such sutures would drop off, the buried loop being absorbed, which, I may add, rarely occurred. Aseptic silk was for many years in general use. At the present date silkworm-gut, as used in "fly fishing," is the favourite material. Being smooth and highly polished it does not irritate, and only undergoes change in the tissues very slowly.

It is a custom with some operators to test the aseptic state of all persons' skins and of all materials mentioned, to which list dressing would be added, by bacteriological cultivations. Instruments were, in the early years of antiseptic surgery, placed simply in carbolic lotion (one in twenty to one in sixty), but to render their asepticity beyond question they are now invariably boiled before and after use.

Under the second heading, viz. alterations made in the conduct of operations, looked at narrowly there would seem not much to be said, for, as I stated in the earlier part of this address, the actual manipulations are much the same now as they were forty years ago in the same class of operation, but nevertheless to the close observer a very real change has been wrought by and through the agency of the antiseptic system; more especially is this seen in the later stages of an operation. The principles, as well as the strict practice of aseptic surgery, fix the attention of the operator to every detail, hence, however simple the operation, it is performed more thoroughly and more carefully. In the next place the knowledge, that once the operation is successfully accomplished, the after well-doing of the patients' wound is assured in all operations of expediency, enables a surgeon, on the one hand, to extend the area of the operation far beyond what was formerly thought justifiable. This is noticed chiefly, no doubt, in operations for malignant disease, yet it is equally noticeable in such operations as herniotomy for the relief of acute strangulation. Formerly the operation was completed as soon as the intestine had been returned, but now thickened omentum is removed, the sac separated and cut away, the operation being completed as for radical cure.

On the other hand, this certainty of the well-doing of wounds has opened out a vast field for the intervention of the surgeon. It is unnecessary I should go through the list of operations, which were not even dreamt of in former days. But bearing upon this I may quote a saying of Sir William Lawrence's, who, when lecturing, dismissed the consideration of the surgery of the kidney in these caustic words, "Thank God, gentlemen, the kidney is out of the reach of the surgeon." But these great changes were rendered possible by the invention of antiseptic surgery, and have been gradually brought about by the perfecting of its technique.

Since the early days of antiseptic surgery a noteworthy change has been made, for whereas formerly every wound was drained by rubber tubes or some modification, it is now comparatively rarely that even quite large wounds are drained, so perfect is the healing process.

But of all the changes that have taken place in operative surgery none seem more striking than that under the third heading, viz. the alterations in the after-treatment of wounds. The febrile stage of forty years ago has been abrogated, and the prolonged suppuration, constant poulticing, and disturbance of wounds which followed, the frequent association of erysipelas, pyæmia, and secondary hæmorrhage, are all things of the past. In their place we find our patients, as soon as they have got over the first few hours of pain and discomfort, lie placidly and contentedly during the healing stage, their wounds untouched often for a week; then when dressed they are found healed, sutures are removed, and the patient pronounced convalescent. This result is the crowning-point of the revolution in the practice effected by the discovery of antiseptic surgery, and no wonder that the whole world unites in offering grateful homage to Lord Lister.

Mr. President, my task is completed, and I now thank you, one and all, for the kind attention you have accorded me. My record of the changes I have witnessed in operative surgery during the last forty-four years has, I fear, seemed somewhat fragmentary and disjointed, but embracing so many topics it could not well be otherwise.

One other point seems to need a word of explanation. I have had to tell much of the past. I felt I could only do this appropriately by adopting the phraseology of those times, and that it would have been out of place to use words and terms in constant use now, but which were then unknown.

Operation for Strangulated Femoral Hernia, and removal of a portion of Omentum, in a Woman aged 82 years and 11 months without anæsthetics—Recovery.

By MALCOLM L. HEPBURN, M.D., F.R.C.S., Surgeon to the Lowestoft Hospital.

I VENTURE to record the following case, not from any special feature of novelty or rarity, but because in these days, when anæsthetics are so skilfully administered, one is not often placed in the position of the pre-anæsthetic days, and therefore can hardly realise what can be done in an emergency without either general or local anæsthesia.

I have no doubt there are many similar cases which have occurred to other practitioners, and I think, if they were recorded, they might encourage some of us junior men, who know little of operative interference without anæsthetics, to feel that there are possibilities which we had almost ceased to expect.

On February 1st, 1901, at 6.15 a.m., I was called to Mrs. L—, aged 82 years and 11 months, who had been operated on twelve years ago for left strangulated femoral hernia, because her rupture had "come down" and she was "unable to get it back." She had worn a truss for several years, and I had been called to her once or twice on previous occasions when she had any difficulty in reducing the swelling.

I found her in great abdominal pain, chiefly referable to the umbilicus, and the hernia was about twice as large as usual, and extremely tense. There was no vomiting, the bowels had acted naturally the previous morning, but her general condition was very critical; her breathing was laboured, she had an anxious expression, her face, usually a fresh colour, was ashy grey, and her pulse scarcely perceptible at the wrist. These symptoms had existed since between 3 and 4 a.m. I sent for my junior partner, Dr. Hutchinson, asking him to bring the anæsthetic, and in the interval I attempted the reduction of the hernia, which I had always been able to accomplish before. However, this time I was unsuccessful, and her condition became so alarming that I felt there was no time to be lost if her life was to be saved, so I determined to operate without delay, before the arrival of my partner. This I proceeded to do with the traditional candle (not fixed in the neck of a bottle this time!) and the traditional old woman by the bedside to help (or look on, as the case might be)!

I made the usual incision over the swelling, which the patient seemed to feel slightly, and, being a thin subject, I soon got down to the sac. Having opened this, I let out some dark-coloured fluid, and found about six inches of small intestine strangulated with some omentum, which was adherent to the sac. The former, though discoloured, was of a character quite capable of returning, so I attempted to reduce again by taxis, but without success. I then incised the

neck of the sac, which gave me a little trouble, as I had only an ordinary scalpel with me, and therefore was afraid of wounding the gut. I was then able to reduce the intestine easily, and there remained a large piece of omentum to deal with, which I left until the arrival of my partner.

Her symptoms were immediately relieved after reduction of the gut, though she was extremely collapsed. However, we proceeded to tie in sections and remove about five inches or so of omentum, and left the stump to block up the crural canal.

She seemed to feel very little of the operation except the skin incision. I then sewed up the opening in the sac in a very rough manner, owing to the patient's condition, and closing the wound with silkworm-gut sutures, I dressed it with iodoform gauze. There was naturally a good deal of collapse after the operation, which I treated in the usual way, though I did not give her any strychnine or morphia.

On returning about three hours later I found she had had some sleep, was fairly comfortable, her pulse 90 and stronger. Temperature was subnormal.

In four hours' time I found her a little better, though she complained of some pain in the upper part of her stomach, which I attributed to flatulence. I ordered her some Liq. Opii Sed. combined with carminatives, to be taken every four hours if necessary. The same evening she was free from pain and comfortable; pulse 108 and temperature subnormal.

The next morning I found she had passed a fair night, but about 8 a.m. had been sick, bringing up some nourishment and medicine, and she still felt some nausea. I satisfied myself that this sickness was due rather to some atonic dyspepsia than anything connected with the hernia, so, in order to keep her alimentary canal quiet, I gave her a hypodermic injection, consisting of strychnine, sulphide, $\frac{1}{50}$ gr., atropine, $\frac{1}{120}$ gr., and morphine sulphate, $\frac{1}{5}$ gr. This was at 10.30 a.m., and at 3.15 p.m., when I saw her again, she was lying in a comatose condition, with stertorous breathing and contracted pupils, from which I could not rouse her. This I attributed afterwards to the effect of the morphia, though at the time I thought she was dying, and gave a very unfavourable prognosis.

In the evening at 9 p.m. she had considerably revived and had taken some nourishment. From this point she gradually improved. The greatest trouble I had was with her atonic dyspepsia, which caused her to wake up often in the early morning with pain in the upper part of the abdomen, with distension of the stomach, and palpitation, which improved on bringing up flatus. Her bowels also were difficult to move at first, as she obstinately refused to have an enema administered; but I gave her small doses of saline frequently, with the result that they were well moved at 1 a.m. on the sixth day, with great benefit to her indigestion.

The wound healed by first intention, and the dressing was left off on the ninth day. By March 1st she was sitting up and taking her food well, with a good action of the bowels every other day, which was her usual custom; and I am glad to say that she is now as well as ever.

I regard the success of this case as due to two causes:

1. Securing the case early.
2. The non-employment of a general anæsthetic.

My previous knowledge of the size of the hernia helped me to make a rapid diagnosis, even in the absence of vomiting; had I waited I am sure the patient would have died. Had I also subjected her to the shock of a general anæsthetic I think, in all probability, this alone would have produced the same result.

I consider I was justified in my decision by the condition of the fluid in the sac, the condition of the gut, the failure to reduce the bowel when freely exposed, and the immediate relief of acute symptoms after reduction. The unreasonableness of the public towards medical men and to operating in particular, was well exemplified also in this case; for although the "traditional old woman" above referred to appeared to be grateful for her recovery, when she saw the patient improving day by day she began to express doubts as to whether the operation was necessary after all. Had she died during the operation, no doubt it would have been due to my interference; and had I left her to die without an attempt to save her, I should have been asked why I did not operate like "the other doctor" did before.

I may as well mention, for the encouragement (?) of enterprising surgeons about to engage in general practice, that in consequence of some of the above logical reasoning on the part of my "traditional" assistant, I am no longer the medical attendant of the old lady; and no language appears strong enough in which to abuse me for my mismanagement and want of attention to her mistress.

Gun-shot Wound of Urethra.—"Cock's Operation."

By E. W. Gurney Masterman, F.R.C.S.

THE operation known as "Cock's operation" is, I believe, no favourite at "Bart.'s," and while there I neither saw it done nor heard it recommended. The following case may be of interest to "Bart.'s men, as one in which I believe this operation proved the best, if not the only one.

A—, a Moslem, native of Hebron, aged about forty, was sent to me, May 11th, by Dr. Paterson of Hebron, with a bullet injury of the urethra.

The patient gave a very confused account of himself, saying that he had been accidentally shot ten days (it is evident it was much longer, probably as many weeks) before coming to me. On admission to our hospital he was found to have a wound (the point of entrance of bullet) in the left groin, in the line of Poupart's ligament, at about the junction of the outer two thirds with the inner one third; the opening was only large enough to admit a probe. The wound of exit was to the inner side of the right buttock. There was also a small wound in the perinæum made by a Bedouin Sheik, who had attempted to let out the urine that way by application of a red-hot iron; this was almost healed. The patient was in a pitiable condition, all the urine and great quantities of pus passing out drop by drop from the wounds of entrance and exit, especially the former; he was soaked with foul-smelling urine. His temperature was hectic, running up from normal or near normal to 102° or 103° every evening.

The wounds were probed with negative result, and several attempts were made with various catheters to re-establish the proper channel; but all in vain.

On May 25th the patient was put under chloroform with the intention of my doing a "Wheelhouse," if possible; when, however, the urethra was opened out in the usual way, not the smallest trace of a passage towards the bladder could be found with the finest probe; the membranous urethra was entirely occluded by scar tissue, the bullet having passed either right across it or close to it. A double-bladed Cock's knife, ready for such an emergency, was taken, and thrust straight inwards to the prostatic urethra with complete success, a finger in the rectum being used as a guide. A large gum-elastic catheter was then passed through the penile urethra, and *vid* the wound into the bladder, and tied in. When at subsequent times attempts were made to pass catheters they were never successful except by passing the instrument out at the wound and in again. I am unaware if this is a common experience after "Cock's operation," but it is a great drawback. Finally the man had to pass all his urine, as he does now, by the perinæum. On the other hand, he soon obtained complete control over it as soon as the tied-in catheters were removed.

Unfortunately this first operation did not give him entire relief, as it was hoped; his hectic temperature continued, and some urine and much pus continued to come from the upper sinus.

Accordingly on June 21st this sinus was laid open under chloroform and a finger introduced. It was found that the pubic bone had been pierced by the bullet, leaving a circular hole near the lower border, and several sequestra were felt with the tip of the finger deep down in the abscess cavity. These were seized with some difficulty with sequestrum forceps, and the cavity thoroughly irrigated.

The improvement following this second operation was immediate; the upper wound rapidly closed; all pain disappeared; temperature became normal, and patient rapidly gained flesh.

In the middle of July the patient insisted on leaving the hospital, being unwilling to submit to any further effort to restore the urethra.

He is now quite well, except that it bothers him a good deal that his semen, during coitus, escapes by the perinæal wound; otherwise all his functions are normal.

This experience of Cock's operation has led me to think it a most valuable one for such exceptional cases as this, and for the operation the special double-bladed "Cock's" knife seems to me far superior to an ordinary single-bladed one, such as one uses in lateral lithotomy.

Jerusalem, Syria;
October 4th, 1901.

Notes.

THE entry of new students at the beginning of the Winter Session, 1901–2, shows that, although there has been a marked decrease in all the medical schools, we still maintain our relative position, and that our entry has not materially varied from that of last year.

The total numbers are 140, of which 84 are for the full curriculum, and 56 for special courses, including the Preliminary Scientific Class.

We give below the entries for the past five years.

Year.	Full course.	Special, including preliminary scientific course.	Total.
1896	84	81	165
1897	97	91	188
1898	100	89	189
1899	115	69	184
1900	87	55	142
1901	84	56	140

The next largest entries among the London schools is that of Guy's, with 68 for the full curriculum, the London Hospital coming third with 64. All other schools are below 50 for the full course. In London only two schools show an increase on the 1900 entry, St. Thomas's being one more and King's two more than last year.

In the provinces Cambridge University alone has a larger entry than Bart.'s, the same number of medical students (115) having entered as in 1900, and even in this case we are doubtful whether the number should be compared with our full entry of 140, or that of 84 for the full curriculum.

One fact at least stands out, that while the entry is still affected by those causes which have led to a general reduction in the number of medical students registering in 1901, yet we maintain our usual relative level.

* * *

DR. CLAYE SHAW has resigned the post of Medical Superintendent at the Middlesex County Asylum, Banstead.

* * *

MR. L. B. RAWLING, F.R.C.S., has been appointed Assistant Surgeon to the German Hospital.

* * *

MR. E. W. BREWERTON, F.R.C.S., has been appointed Assistant Surgeon to the Royal Westminster Ophthalmic Hospital.

* * *

J. L. SHRUBSALL, M.A., M.B.Cantab., and EUSTACE TALBOT, M.A., M.B.Cantab., have been admitted Members of the Royal College of Physicians.

* * *

A NEW series of lectures has been instituted this session; the assistant physicians and surgeons in charge of the various special departments now deliver lectures in their several subjects on Mondays at 1 p.m. in rotation. We welcome gladly this extension of teaching by clinical lectures as a valuable addition to the practical instruction at the Hospital.

* * *

A NEW departure in the course of lectures by Dr. Claye Shaw on Psychological Medicine has commenced this session, a series of demonstrations on this subject being given by Dr. Horder at the close of the lectures.

* * *

ONCE more Bart.'s is to be congratulated on the successes in London University M.B. finals, six men having been placed in the First Division out of thirteen candidates.

* * *

FAR be it from us to venture to disagree with the scientific basis of phantoms and spooks propounded by Sir Lauder Brunton in his lecture before the Medico-Psychological Society, but it wounds us sorely to think that our best family ghost, our only claim to "blue blood," may have so unromantic an origin as "a fit in the surgery, sir!"

* * *

THE Rugby XV have started the season in great form; so far they have an unbeaten record—long may it remain so. It would be no unwise thing, too, if the Inter-hospital Cup were to find a resting-place on the Library table; to the Cup itself the surroundings would be strangely unfamiliar.

* * *

WE hear that the V.M.S.C. ball was an even greater triumph than usual. We must congratulate most heartily those who were responsible for its organisation. Complaints have, however, reached the editorial ear that the fair sex showed an undue preference for one corps, which shall be nameless. To would-be recruits who are undecided what corps to join we will send the name (under cover) on receipt of our usual fee for "a written opinion."

* * *

THE Government is opening up a fresh sphere of work for civil surgeons in South Africa. Applications are now invited from medical men to work in the Boer concentration camps. The rate of pay offered is twenty-five shillings a day all found.

* * *

THE City Coroner has caused much heart-searching in "quarters" by deciding that medical witnesses are to be present throughout the inquest until their evidence has been given; still this consolation remains, the Coroner's Court might be two miles away.

* * *

IN our report of Dr. Gee's Clinical Lecture last month the name "Cotunio" was printed for "Cotugno." We take the opportunity of correcting the error.

Amalgamated Clubs.

RUGBY FOOTBALL CLUB.

Officers 1901-2.

President.—A. Bowlby, Esq., C.M.G., F.R.C.S.
Vice-Presidents.—J. S. Sloane, Esq., F.R.C.S.; W. F. Bennett, Esq., M.R.C.S., L.R.C.P.; H. J. W. Wells, Esq., M.R.C.S., L.R.C.P.; H. C. Adams, Esq., M.R.C.S., L.R.C.P.
Captain 1st XV.—A. O'Neill.
Vice-Captain.—H. E. Stanger-Leathes.
Hon. Secretary.—H. E. Stanger-Leathes.
Assistant Hon. Secretary.—C. H. Cross.
Captain 2nd XV.—W. H. Scott.
Committee.—L. R. Tosswill, A. R. Neligan, H. T. Wilson, F. Harvey, B. N. Ash, W. H. Hamilton, R. M. Miller, J. Corbin.

1st XV Fixtures.

Date.	*Opponents.*	*Ground.*
1901.		
Oct. 12	London Irish	Herne Hill.
,, 19	Park House	Winchmore Hill.
,, 26	Marlborough Nomads	Surbiton.
Nov. 2	Croydon	Croydon.
,, 6	R.I.E.C.	Cooper's Hill.
,, 9	Upper Clapton	Winchmore Hill.
,, 20	Rosslyn Park	Richmond.
,, 23	Harlequins	Wandsworth.
,, 30	Old Leysians	Winchmore Hill.
Dec. 4	R.M.A.	Woolwich.
,, 11	R.N.C.	Winchmore Hill.
,, 14	Streatham	Streatham.
1902.		
Jan. 11	Lennox	Stamford Bridge.
,, 15	Royal Engineers	Chatham.
,, 18	Catford Bridge	Winchmore Hill.
,, 25	Bedford	Bedford.
,, 29	Rosslyn Park	Winchmore Hill.
Feb. 1	Northampton	Northampton.
,, 15	Portsmouth	Portsmouth.
March 1	Old Leysians	Eltham.

There is also a strong list of 2nd XV fixtures.

St. Bart.'s *v.* London Irish.

Played at Herne Hill, October 12th, 1901. This match, the first on the hospital fixture list, resulted in a very good game, and eventually the hospital was left victorious by a goal (dropped) and a try, or 7 points to *nil*.

Both teams were fairly well represented, and a good game was anticipated. The Hospital, who have the whole of last year's cup-tie team, and some promising "freshers" to choose from, ought to be able to put fairly representative teams into the field for their ordinary matches, and with a little more confidence in themselves, and a good understanding between the front and back divisions, which, unfortunately, was lacking last year, they have every chance of a successful season.

O'Neill won the toss, and the Irish kicked off, Corbin returning well into touch. The play to begin with was of the scrambling order in mid-field, then the Irish forwards made a rush, which was well stopped by Neligan. The Hospital forwards were beginning to settle down, and it was seen that the packs were well matched. Bart.'s were working well, and gradually took the ball down the field, aided by a good dribble by N. M. Wilson; however, the Irish captain got possession, and breaking through the hospital defence, carried the game into the visitors' half. It did not remain here long, as the Hospital forwards, using their feet well, with a series of short rushes, brought the ball back to the Irish "25." A strong attack was made on the home goal, which was unsuccessful for some time. From a scrum Stanger-Leathes came away, and, with a good dribble, carried it to the goal line, and the ball bouncing off him to H. T. Wilson, the latter was able to score the first points for the Hospital. Stone's kick at goal failed.

The Irish dropped out, and following up well, were able to keep the play in mid-field. The Hospital halves were not playing together, and the Irish were enabled to carry the game into the visitors' "25." A penalty kick was unsuccessful, and Corbin was able to find touch well down the line. The Irish came back again, and were attacking strong, when Drury and Marshall brought off two neat collars, and Stone relieved with a good kick. The game went on outside the Hospital "25," and became rather ragged about this time. A. O'Neill was prominent in heading some rushes, being well backed up by Tosswill. There seemed to be a lack of proper combination amongst the remainder of the forwards, and the Irish had no difficulty in stopping individual efforts. The Irish again came back, and must have scored but for some mistakes in handling the ball. Half time came with the Irish pressing.

The game had so far been very well contested, and there was nothing to choose between the two teams. Bart.'s were leading by 3 points to *nil*. O'Neill kicked off, and it was well followed up, the Irishman being tackled before he was able to get in his kick. The Bart.'s forwards were now working well together, and time after time, getting control over the ball, were heeling out neatly; many small rounds of passing were witnessed, but the Irish tackled well. The visiting forwards were next prominent with a beautiful combined rush, and the Irish goal line was in danger. A kick by the Irish back relieved, and the game became very fast. Corbin was seen to mark his man very well two or three times, and Tosswill was prominent out of touch. The game was still raging in the home "25" when Magee got the ball and raced down the field, and would have scored but for Singh's pace, who caught him up and forced him to pass, which was, however, not accepted, and thus the Irishmen lost another chance of scoring.

Magee's run was the best of the game. After this excitement Bart.'s were seen to best advantage, and the forwards and backs were working well together. The ball was swiftly carried to the Irish "25," and the Hospital made repeated efforts to score without success. From a scrum on the "25" line the ball came out well, and N. M. Wilson passing to Drury, and he to Stone, enabled the last named to drop a neat goal. After this play was chiefly confined to mid-field. About six minutes from the end N. M. Wilson was hurt, and had to retire. The Irish pressed for a short time, then Stone was prominent with a good run, and eventually the whistle blew "no side," when play was in mid-field.

The Hospital forwards shaped very well in the second half, and the kicking, especially of Stone and Corbin, was of high order.

T. O'Neill at half was very safe, but had few chances of showing up.

K. S. Singh at three-quarters appeared to be nervous, but towards the end of the game brought off some excellent collars, and when he holds his passes better, with his turn of speed, ought to make a good wing three-quarter. Teams:

St. Bart.'s Hosp.—E. S. Marshall (back); D. M. Stone, J. Corbin, G. D. Drury, K. S. Singh (three-quarters); T. O'Neill and N. M. Wilson (halves); A. O'Neill, L. R. Tosswill, H. T. Wilson, A. R. Neligan, H. E. Stanger-Leathes, C. R. Hoskyn, T. A. Izard, A. Ryland (forwards).

London Irish.—R. T. Quane (back); V. H. Woodley, A. T. Watson, F. S. Forde, J. Hehir (three-quarters); G. Sloane, L. M. Magee (Captain) (halves); G. C. Walsh, T. Otway-Ruthven, A. F. G. Moran, B. C. Casey, J. N. Walsh, C. L. Townsend, J. J. Rahilly, M. F. Kelly (forwards).

St. Bart.'s Hospital *v.* Park House.

This match was played at Winchmore Hill on October 19th. The Hospital, although without A. O'Neill, Ash, Stone, and Neligan, won by two goals (one penalty) and one try to *nil*. In the first half, although Bart.'s had somewhat the best of the game, the only score was a fine penalty goal by Wilson. In the second half of the game the Hospital played up much better, and Wilson, picking up from a loose rush, soon scored a try, which he failed to convert. Soon after this Hamilton, getting possession from a line-out, scored another try, which Wilson easily converted. After this Park House looked dangerous, but relief soon came, and the whistle blew with play in mid-field, Bart.'s running as stated above.

For the Hospital, the forwards, although O'Neill was greatly missed, played a good game throughout, Tosswill and Wilson being especially prominent; and T. O'Neill and Hamilton played well at half. H. B. Owen made a promising *début* in the three-quarter line, which combined much better than in the first match, but there is still room for improvement. Team:

St. Bart.'s.—E. S. Marshall (back); K. S. Singh, J. Corbin, H. B. Owen, G. D. Drury (three-quarters); W. H. Hamilton and T. O'Neill (halves); L. R. Tosswill, H. T. Wilson, H. E. Stanger-Leathes, A. Ryland, J. Morris, R. M. Miller, T. A. Izard, C. R. Hoskyn (forwards).

Referee: Mr. G. B. Harris (L.R.U.S.R.); *Touch-judge:* J. Cleveland.

ST. BART.'S HOSPITAL *v.* MARLBOROUGH NOMADS.

The Hospital team travelled down to Surbiton for this match on October 26th, but on arrival there the fog was found to be so thick that play was out of the question, so the match was abandoned. Teams:

St. Bart.'s Hospital.—E. S. Marshall (back); D. M. Stone, J. Corbin, H. B. Owen, G. D. Drury (three-quarters); W. H. Hamilton and T. O'Neill (halves); L. R. Tosswill, H. T. Wilson, H. E. Stanger-Leathes, J. Morris, A. Ryland, R. M. Miller, T. A. Izard, C. R. Hoskyn.

Marlborough Nomads.—J. R. Godson (back); A. W. Porter, F. A. Mily. N. C. Phillips, J. L. A. Cock (three-quarters); G. L. Soames and E. C. Hughes (halves); E. C. Galloway, B. A. Howard, G. H. Adam, L. E. Reeves, T. S. Foster, H. E. Parker, W. G. Munsee, and W. P. Johnstone (forwards).

Referee: Mr. E. V. Gardiner (L.R.U.S.R.).

"A" TEAM.

ST. BART.'S *v.* OLD CHARLTONIANS.

At Winchmore Hill, October 12th. Won 1 goal (5 points) to 1 try (3 points); try for Hospital gained by Ash.

ST. BART.'S *v.* PARK HOUSE "A."

At Kidbrooke, October 19th. Won 3 goals (15 points) to 1 goal 1 try (8 points); tries for Hospital gained by Wilson, Plews, and Cross.

ST. BART.'S *v.* UPPER CLAPTON "A."

At Winchmore Hill, October 26th. Won 2 tries (6 points) to 1 try (3 points); tries for Hospital gained by Brewer and Haines.

ST. BART.'S *v.* CROYDON "A."

At Winchmore Hill, November 2nd. Lost 2 goals 3 tries (19 points) to 1 try (3 points); try for Hospital gained by Haines.

ST. BART.'S *v.* CENTRAL TECHNICAL COLLEGE.

At Acton, November 9th. Won 3 goals 4 tries (27 points) to a try (3 points); tries for Hospital by Haines (2), Wilson (3), Plews (1), Kindrew (1).

ASSOCIATION FOOTBALL CLUB.

PAST *v.* PRESENT.

Played at Winchmore Hill, Wednesday, October 9th. Result, Present 3, Past 1.

The game started by both sides being two men short. Soon after the start some good passing by the insides enabled O'Brien to get through and score. Then the other men arrived, and the two teams soon got well together. The defence on both sides was too strong for the forwards. At half time the score was 2 to 1, Ward and O'Brien scoring for their respective sides.

In the second half the game slackened, and only one goal was scored by a good shot from Griffin. For the Past V. G. Ward and L. Orton were the best, while C. O'Brien and W. S. Nealor played well for the Present. Teams:

Past.—(Goal) T. Holtby; (backs) L. Orton, J. R. Lloyd; (half-backs) W. Jones, T. Taylor, F. Jackson; (forwards) H. N. Marrett, V. G. Ward, K. S. Singh, A. N. Other, L. Gröne.

Present.—(Goal) J. Griffin; (backs) W. S. Nealor, G. B. Scott; (half-backs) H. B. Scott, V. C. Upton, N. E. Waterfield; (forwards) G. B. Griffin, C. LeBrocq, C. W. O'Brien, A. H. Hogarth, T Kilby.

ST. BART.'S *v.* R.M.A.

Played at Woolwich, Wednesday, October 23rd. Result, St. Bart.'s 2, R.M.A. 1.

The game started with a lot of play in mid-field, Bart.'s, if anything, having slightly the better of the exchanges. Then their right wing took the ball down, and ended up with a good shot, which Griffin just succeeded in saving, but their centre forward scored immediately afterwards.

Soon after O'Brien scored for Bart.'s, and just before half-time Honiball added one more. In the second half no more goals were scored. For the R.M.A. the centre forward and right back were best, while Nealor, O'Brien, and Jones played well for Bart.'s.

Same team as against R.I.E.C.

ST. BART.'S *v.* R.I.E.C.

At Cooper's Hill. Result, R I.E.C. 4, St. Bart.'s 3.

This proved to be one of the best games we have had. The R.I.E.C. scored first, and then each side scored alternately till the final score was reached. Farr played well for the R.I.E.C. The halves played a sound game for the Hospital. Team:

(Goal) J. Griffin; (backs) W. S. Nealor, J. R. Lloyd; (half-backs) W. Jones, V. C. Upton, N. E Waterfield; (forwards) G. B. Griffin, R. C Berryman, C. O'Brien, W. Honiball, T. Kilby.

ST. BART.'S *v.* OLD CRANLEIGHANS.

Played at Winchmore Hill, November 2nd. Result, Bart.'s 4, Old Cranleighans 3.

Bart.'s started off well, and scored 4 goals in the first half; then the forwards seemed to collapse for the rest of the game. In the last half the Old Cranleighans scored 3 goals. Team:

(Goal) J. Griffin; (backs) W. S. Nealor, J. R. Lloyd; (half-backs) W. Jones, V. C. Upton, N. E. Waterfield; (forwards) G. B. Griffin, A. H. Hogarth, C. O. Brien, R. Berryman, T. Kilby.

ST. BART.'S *v.* CASUALS.

The Casuals brought up a very strong team, and were far too good for Bart.'s C. Drake and V. G. Ward played very well for the visitors, W. S. Nealor played well for St. Bart.'s.

Result, Casuals 7, Bart.'s 1. Team:

(Goal) J. Griffin; (backs) W. S. Nealor, J. R. Lloyd; (half-backs) W. Jones, V. C. Upton, N. E. Waterfield; (forwards) G. B. Griffin, C. E. A Armitage, C. O'Brien, A. H. Hogarth, T. Kilby.

HOCKEY.

ST. BART.'S "A" *v.* BLACKHEATH SCHOOL.

This match was played at Blackheath on October 30th, and resulted in an easy win for the Hospital by 6 goals to *nil*. Goals by Adams (3), Grant, Fowler, and Hallowes. Team:

Phillips, Sowerby, Scott, Adam, Wright, Fowler, Grant, Jendwine, G. H. Adam, Hanbury, Hallowes.

ST. BART.'S *v.* UXBRIDGE.

This game was decided at Uxbridge on November 2nd, and after a fast game resulted in an easy win for the Hospital by 6 goals to one. Play was very even at first, but then the visitors' combination amongst the forwards improved, and goals were scored by Beckett, Sale, and Gray, the home team scoring once. During the second half of the game Bart.'s were again seen to advantage, and three more goals were scored by Fowler, Wilmot, and Hallowes. L. Orton at back played well. Team:

Orton, Phillips, A. N. Other (backs); Fowler, Wright, and Adam (halves); Gray, Wilmot, Beckett, Sale, Hallowes (forwards).

ST. BART.'S *v.* ST. ALBANS.

We met St. Albans on their own ground on November 9th, and the game resulted in a win for St. Albans by 6 goals to 1.

During the first quarter of an hour we pressed them, the forwards playing well together, and Beckett dribbling the ball up the field scored one goal. The play then became more even until Boys shot their first goal. In the second half they pressed us most of the time, their forwards showing excellent combination. The Hospital was represented by:

Sowerby, Phillips, Fowler (backs); Murphy, Hill, Adam (halves); Gray, Graham, Beckett, Jendwine, Hallowes.

ST. BART.'S *v.* R.M.A.

This match was played at Woolwich on November 13th, and resulted in a win for the R.M.A. by 7 goals to 3. Although the game was won by such a margin it was very even. Raikes and Beckett made several excellent shots at goal, but each time their goal-keeper managed to save. Our forwards played well together. Goals by Hallowes, Beckett, and Raikes. Team:

Cross, Fowler, Sowerby (backs); A. N. Other, H. B. Hill, (halves); H. Gray, G. H. Adam, Beckett, Raikes, Hallowes (forwards).

UNITED HOSPITALS' HARE AND HOUNDS.

This club, which had of late years almost died out of existence, has suddenly sprung once more into favour, especially at this Hospital, where we have some good cross-country runners.

The programme for the season, although still open to changes, is this—

December 7th.—Six-miles match with Wellington College at Wellington.

December 21st.—Eight-miles match with the Woodside A.C.

January 18th.—Five-miles race with the Ranelagh Harriers at Putney.

February 8th.—Inter-Hospital ten miles race to be run either at Epping Forest or at Blackheath.

February 21st.—A six miles match with Dublin University at Dublin.

Matches with the Thames Hare and Hounds and the Blackheath Harriers are also being arranged.

Unless we have very hard luck, as happened last year, and lose most of our best men just before the race, we ought to win the Inter-Hospital Cup fairly easily, as J. G. Gibb, who won the ten miles this spring, and the Inter-Hospital three miles for us, is almost certain to be first man in again, while H. Barnett, S. F. Lister, G. M. Levick, A. C. Wilson, P. Gosse, T. Bates, and others are running twice a week now, so ought to be pretty fit by the time the team is chosen to run for the United Hospitals' Hare and Hounds.

Abernethian Society.

Session 1901—1902.

Officers.

Presidents:—W. S. Danks, F. C. Shrubsall.
Vice-Presidents:—N. E. Waterfield, N. Maclaren.
Treasurer:—Norman Moore.
Hon. Secretaries:—H. J. Slade, T. J. Faulder.
Additional Committeemen:—A. R. Neligan, V. C. Upton.

THE opening meeting of the session was held on October 10th, in the Anatomical Theatre, Mr. Danks in the chair supported by the Committee. Mr. Willett read a paper, styled "A Historical Review of Changes of Procedure in the Treatment of Operation Wounds at St. Bartholomew's Hospital, 1857—1901." The paper, which is reported in full, elicited loud applause from an interested house.

The chairman having made an appropriate speech, a vote of thanks to Mr. Willett was proposed by Mr. Bull, seconded by Mr. Gask, the former being inspired by Mr. Willett's hint that his address was "valedictory to some," the latter by Mr. Willett's long connection with the Abernethian Society as its Treasurer. Their proposal was carried *uno animo*. A goodly number of the nursing staff were present.

The second meeting of the session was held on October 17th, Mr. Danks in the chair. Mr. Talbot read a paper on "The Modern Treatment of Pulmonary Tuberculosis."

The curability of the disease was a modern conception, for which Laennec with his stethoscope, and Koch with his microscope paved the way, early diagnosis being thereby rendered possible. For "real cure" early diagnosis was essential, and this was often extremely difficult to make. The author then described a typical "early" case, with possible lines of treatment. Financial considerations permitting these were three—(i) climatic, (ii) sanatorium, (iii) a combination of the two.

For most cases he considered that a "dry cold" climate, such as that of the high Swiss valleys, was best.

He described in detail the routine of the modern sanatorium. The salient points were,—abundant food and fresh air in all cases, rest and exercise arranged to suit individuals, everything being regulated by the doctor, whose chief guide was the temperature chart. He discussed the use of drugs, and considered the effects of creasote, etc., and formalin, upon local lesions. He deprecated the loose use of the word "cure," and postulated at least two clear years of freedom from ominous symptoms.

The propriety of recommending the special treatments to patients was discussed, and the dilemma attending the doctor illustrated by the somewhat lugubrious aphorism, that the only thing a physician can be certain of in giving a definite diagnosis of chronic tuberculosis is that he will be wrong.

A sea voyage was a perilous prescription from the conditions thereof.

In reference to the poorer classes the author gave his experiences at the Chest Hospital. There were two main difficulties in the way of adequate treatment—(i) the impossibility of getting hold of "early" cases, (ii) difficulty in retaining them. The result was a mere patching up, rarely a "cure."

The paper concluded with a summary of the main points elucidated.

A clinical evening was held on October 24th, Mr. Shrubsall presiding.

Mr. Pridham showed a case of periosteal nodes in a child æt. 6, the left humerus, right radius and ulna, and both tibiæ being affected. There was a history of snuffles and of some rash, and the disease had appeared somewhat suddenly. There were no other signs of congenital syphilis, and mercury produced no effect. The case was debated by Messrs. Shrubsall, Bull, Tweedy, and Littler-Jones.

Mr. Niall showed a case of a woman, æt. 49, a widow, who had a large fluid swelling in the left hypochondrium and left lumbar region. The swelling was connected with the left lobe of the liver; the right lobe was not enlarged. It was of twelve months' duration, and had increased lately. There was no pain; no blood had been passed, and the bowels were regular. There was also dulness behind, reaching up to the inferior angle of the left scapula, which might possibly be an independent tumour of the spleen. The case had previously been taken for carcinoma of the liver.

Mr. Shrubsall showed a case of intractable skin disease, a boy æt. 8, who had extensive papular eruption with intense itching. He also showed a microscopic section of a papule, stating that it suggested Hebra's prurigo. Treatment for a possible parasite *fons et origo mali* was advocated by Mr. Litler-Jones, opposed by Mr. Pridham. Mr. Picton pointed out the virtue of baths followed by inunction (statim) of oil.

Mr. Pridham showed a case of spastic ataxia, a man æt. 38. He gave a very lucid account of the disease and of the diagnosis. The spastic part of the disease was not well marked; this was explained by improvement in the patient's condition.

Mr. Picton showed a case of muscular atrophy in an ex-dragoon, æt. 28, who had seen six years in India. The adductor muscles were first attacked; the onset of the disease was acute, and there had been recurrent attacks of wasting. He was in favour of its being peripheral neuritis, induced, possibly, by intoxication from some tropical disease. A keen debate followed, Messrs. Shrubsall, Izard, Pridham, Niall, Tweedy, and Picton taking part.

Mr. Scholberg showed specimens, micro- and macroscopic, of tubercle of the meninges of the brain and pons, also a specimen of hæmorrhagic pancreatitis.

Mr. Bull showed specimens of supernumerary auricle and umbilical papilloma.

Mr. E. Shaw brought four microscopic specimens of his own.
(i) Carcinoma and fibro-adenoma of breast.
(ii) Process of absorption of silk ligature.
(iii) Vermiform appendix containing oxyuris vermicularis.
(iv) Oxyuris vermicularis from the same appendix.

He also showed a specimen of phagocytosis, showing removal of red blood-cells by leucocyte, lent by Dr. Andrewes.

Programme of the Session.

1901.	*Author's Name.*	*Subject of Paper.*
June 27,—	Dr. Ormerod	The History of our Special Departments.
Oct. 10,—	Mr. Willett, F.R.C.S. ...	An Historical Review of Changes in procedure in the Treatment of Operation Wounds at St. Bartholomew's Hospital between 1857 and 1901.
„ 17,—	Mr. E. Talbot, M.B.	The Modern Treatment of Pulmonary Tuberculosis.
„ 24,—	....	Discussions, Clinical and Pathological.

Oct. 31,—	Mr. G. V. Bull, M.B.	Some Forms of Cirrhosis in Children.
Nov. 7,—	Mr. J. A. Nixon, M.B. ...	The Evolution of the Medical School.
„ 14,—	Mr. G. E. Gask, F.R.C.S.	The Dangers and Difficulties in Minor Surgical Operations.
„ 21,—	.....	Discussions, Clinical and Pathological.
„ 28,—	Mr. F. A. Bainbridge, M.B., B.Sc., M.R.C.P.	Some Neuroses in Children.
Dec. 5,—	Mr. S. B. Atkinson, LL.M., B.Sc.	The Law of Negligence in its Relation to Medical Men.
„ 12,—	Mr. S. R. Scott, M.B. ...	
1902.		
Jan. 9,—	Dr. Champneys	Some Pages from the Ancient History of Obstetric Medicine and Surgery.
„ 16,—	Mr. C. E. West, M.R.C.S., L.R.C.P.	Some Innocent Tumours of the Breast.
„ 23,—	.....	Discussions, Clinical and Pathological.
„ 30,—	Mr. Litler-Jones, M.R.C.S., L.R.C.P.	Concerning Arthritis.
Feb. 6,—	Mr. W. D. Harmer, M.C., F.R.C.S.	The Diagnosis, Prognosis, and Treatment of Intussusception.
„ 13,—	Dr. Clive Rivière	Tuberculosis in Children.
„ 20,—	.....	Discussions, Clinical and Pathological.
„ 27,—	Mr. M. H. Gordon, M.A., M.B.	The Bacteriology of Scarlatina.
Mar. 6,—	Mr. L. J. Picton, M.B. ...	Chlorosis.
„ 13,—	.....	Discussions, Clinical and Pathological.
„ 20,—	.....	Annual General Meeting.

Cambridge Graduates' Club of St. Bartholomew's Hospital.

THE twenty-sixth annual dinner of this club was held at Frascati's on Wednesday, November 13th, Dr. E. G. Browne (Pembroke College, University Lecturer on Persian) being in the Chair.

After the usual loyal toasts the Chairman proposed the toast of the Club. He gave a most interesting account of his sojourn in Persia, and of the primitive state of medicine in that country. He gave an account of the reasons that made him give up the practice of medicine to study Persian. He gave the Persian definition of a poet as one who made the great appear small and the small appear great, and so the small embarked on great enterprises, and as he had been called upon to take the Chair the Secretary must be regarded as a poet, as it was a great enterprise for him to leave his Persian lectures, which were attended by ten or twelve at most, to address so large a gathering of his university and hospital friends.

Mr. Holmes Spicer proposed the toast of the Guests, which was replied to by Lieut.-Colonel Keogh, R.A.M C., Mr. Kemp, K.C., the Secretary of the Royal Society, and Dr. Herringham, of Oxford.

Lieut. Colonel Keogh spoke of the new organisation of the R.A.M.C. He complained that the medical profession had not taken that interest in the Service which they had the right to expect; they argued that the army should make it a good thing and they would get good men; but he maintained that if they got the good men they would make it a good thing. In future promotion was to go more by professional merit and not by mere seniority. Qualified men would no longer be subjected to the indignity of a students' examination at Netley, except in clinical medicine and clinical surgery, that the lieutenants would be required to learn only those military matters that belonged to the rank immediately above them, and so on, and not all *en masse*, as at present. He paid a great tribute to those who had come forward as civil surgeons in a time of national emergency, several of whom were present that evening.

Mr. Kemp., K.C., in a witty speech, expressed surprise that a company of medical men should drink anybody's health.

Dr. Rolleston proposed the Chairman's health, which was replied to, and the Chairman proposed the health of the Secretaries (Dr. Fletcher and Dr. Horton Smith), by whose energies the Club was kept going, and they both replied.

About eighty sat down to dinner, and during the evening there were several songs, and a most enjoyable evening was spent.

The Rahere Lodge, No. 2546.

A MEETING of the Rahere Lodge, No. 2546, was held on October 8th, at Frascati's Restaurant, Oxford Street, W., W. Bro. Phineas S. Abraham, M.D., W.M., being in the chair. Bro. Whitaker was raised to the degree of Master Mason, while Bros. Keown and Scott were passed to the Second Degree. Mr. Arthur J. Edge, M.B.(Lond.), M.R.C.S , L.R.C.P., was initiated into Freemasonry, and Bro. T. B. Carlyon, M.R.C.S., L.R.C.P., M.M., St. George's Lodge, No. 125, was unanimously elected a member of the Lodge. The brethren and a number of guests afterwards dined together.

Review.

MEMOIRS AND LETTERS OF JAMES PAGET, edited by STEPHEN PAGET. Longmans, Green, and Co. Price 12*s.* 6*d.* Pp. 429, illustrated.

That the life of Sir James Paget should be preserved to the world is, to any Bart.'s man, not a matter for comment, and we feel no introduction or recommendation from us is necessary for this work, which is in the main an autobiography from the ready pen of Sir James. The book is no mere catalogue of the doings and sayings of one man, but is a complete history and commentary on manners and customs in the medical profession during sixty years, chronicled by one who was as expert in observing as he was fluent and precise in describing; and herein lies its value; the professional life of Sir James Paget was to a certain extent public property, and any biographer, however able, must have merely repeated a great deal of what was already well known. He had been too much in the eye of the public and of the hospital for his attainments and personality to pass unknown, but there were chapters in his life, telling, maybe, of his early struggles with poverty, of his fight against influence in high places, and of his final triumph over what to us may now seem indefensible customs, which could only be made known in an autobiography. And these pages in his life are the most valuable; they show us the process which moulds a great mind.

Of the courage of those days of waiting from 1836 to 1843, hardly expecting to defeat vested interests and reach the goal of his ambition, the staff of Bart.'s, yet loth to retire from a contest for which, with all his modesty, he knew himself peculiarly fitted, the biographer treats at some length, but the interest never flags; this is perhaps the best chapter in the book.

The impatience which Sir James evinced for any form of private tuition deprived him of one of the more profitable ways of bridging the gap, yet there is no doubt that it was this very fact that enhanced so greatly his value as a teacher or observer, for he spent those years immediately following his qualification in writing, and for his writing extensive and varied reading was necessary,—that "fine confused feeding" which John Brown encourages as being the key to the "old manly intellectual and literary culture of the days of Sydenham and Arbuthnot, Heberden and Gregory." To the day of his death no man set a finer example of this "manly intellectual and literary culture" than did Sir James Paget.

It is surprising to read, knowing, as we do, to what a height he cultivated the faculty of clinical observation, that during these seven years he was hardly ever in a hospital ward, and had no opportunity for clinical study.

Promotion when it came, in 1843, did not promise to lead to anything more permanent, in fact it was the inclusion of physiology in the curriculum, a subject of which the rest of the candidates were profoundly ignorant, that gave Paget his opportunity, and opened to him the higher appointments on the hospital staff.

Then followed the revival, or perhaps the foundation of the Hospital Medical School, which previously had sunk to its lowest ebb, its very existence being threatened by the private schools, of which the Aldersgate and Windmill Street are perhaps the best-known examples. His progress from this time forward was slow but steady. As a lecturer he achieved a well-deserved reputation, which will linger in the Hospital for many a long year, while as a surgeon his fame is so well established that neither these nor any other memoirs can enhance it.

But we prize the book, not so much for the mere record of the life and doings of one of our greatest surgeons, but for the insight it offers to his personality, and the knowledge it gives of the man himself; throughout its pages it is not Sir James Paget the talented student, the eminent pathologist, the gifted lecturer, or the able surgeon, it is the man whom we knew, whose character is so fully described in the memoirs, that we cannot refrain from quoting it at length: "He had done more than can be told in these twenty-eight years (*i. e.* from the date of his appointment as Lecturer on Physiology and Warden of the College to the time of his resigning the post of Surgeon in 1871) for the Hospital. He had never ceased working for it; and the present greatness of the School is due, in a very high degree, to him. He brought to it not only his love of work, but also a mind free from envy, hatred, malice, and all uncharitableness, and a determination not to quarrel with anybody, to 'think of things to the exclusion of persons,' to make his work his one claim on the Hospital, and to be paid in more work. But if he had brought no more than this he would not have obtained his profound influence over the students. He had other gifts that kept him from being hard or formidable—light-hearted enjoyment of small pleasures, blank indifference to small hardships, infinite courtesy, love of home life and hospitality, generosity with his money, and a chivalrous disregard of his health. It was this union in him of an austere will with an emotional temperament that drew younger men to him. He was, indeed, more emotional than men knew. If this account of his life is to have any real value it must record that aspect of his nature which he seldom showed to the world. Everybody remembers him as a great surgeon and pathologist, an eloquent speaker, a man of science, strong-willed, and reticent. But those who were always with him saw the wonder of the sensitive side of his nature, his keen enjoyment of a good laugh or a day's holiday, his love of music, his miserable depression in illness, his life of prayer, his many acts of charity, and how he would break down, sometimes, over words that touched him, and how, on rare occasions, he would flare up over something brutal or imbecile said or done. The beauty of his spiritual life came just of this working together of the will and incalculable emotions in him, and it was for his whole nature, not for his strong will alone, that the students almost worshipped him."

Mr. Stephen Paget's task in editing these memoirs was no easy one, to amplify the autobiography of so ready a writer as Sir James called for unusual delicacy and skill, yet the attempt has been completely successful; Mr. Paget has let his father tell the story of his own life, and the details of his early career are allowed to stand as he set them forth; there is no attempt made to add anything adulatory to the account which Sir James Paget, with modest self-confidence, gives of his disappointments and successes.

Yet those traits in a man's character which an autobiography must of necessity fail to bring out the editor has preserved for a grateful posterity. The letters at the end of the volume add not a little to its value and interest; apart from the light they throw on various phases in Paget's life, they stand out as models in an age when the refinements of letter writing—lucidity, conciseness, and elegance of expression—bid fair to be lost.

To Bart.'s men this life of Sir James Paget, edited by the sympathetic hand of his son, who was exceptionally fitted to undertake the work, will prove an engrossing book; while, to the world at large, whether lay or medical, it is a valuable addition to biographical literature.

Calendar.

November, 1901.

Nov. 21.—Abernethian Society. Clinical Evening.
" 22.—Dr. Gee's Clinic.
Dr. Hensley and Mr. Butlin's duty.
" 23.—Hockey Club *v.* Oxford Casuals at Oxford.
A.F.C. *v.* West Norwood at West Norwood.
R.F.C. *v.* Harlequins at Wandsworth.
" 25.—Mr. Cumberbatch. Special Lecture.
" 26.—Sir J. Lauder Brunton and Mr. Walsham's duty.
" 27.—Mr. Marsh's Clinic.
" 28.—Abernethian Society. Paper by Mr. Bainbridge, "Some Neuroses in Children."
" 29.—Sir Dyce Duckworth's Clinic.
Sir W. S. Church and Mr. Willett's duty.
" 30.—A.F.C. *v.* Nondescripts (Camb.) at Winchmore Hill.
R.F.C. *v.* Old Leysians at Winchmore Hill.
Hockey Club *v.* Crystal Palace at Crystal Palace.
Dec. 2.—Dr. Ormerod. Special Lecture.
" 3.—Dr. Gee and Mr. Langton's duty.
" 4.—Mr. Marsh's Clinic.
R.F.C. *v.* R.M.A. at Woolwich.
" 5.—Abernethian Society. Paper by Mr. S. B. Atkinson, "The Law of Negligence in its Relation to Medical Men."
" 6.—Dr. Hensley's Clinic.
Sir Dyce Duckworth and Mr. Marsh's duty.
" 7.—Hockey Club *v.* Hendon at Winchmore Hill.
" 9.—Mr. Bruce Clarke. Special Lecture.
" 10.—Dr. Hensley and Mr. Butlin's duty.
" 11.—Mr. Marsh's Clinic.
R.F.C. *v.* R.N.C. at Winchmore Hill.
" 12.—Abernethian Society.
" 13.—Sir W. S. Church and Mr. Willett's duty.
Sir J. Lauder Brunton's Clinic.
" 14.—A.F.C. *v.* Idlers at Winchmore Hill.
Hockey Club *v.* Tulse Hill at East Dulwich.
R.F.C. *v.* Streatham at Streatham.
" 16.—Mr. Bowlby. Special Lecture.

Examinations.

UNIVERSITY OF LONDON.

Examination for Honours.

E. E. Maples, Gold Medal and First-Class Honours in Anatomy; First-Class Honours in Materia Medica and Pharmaceutical Chemistry; Second-Class Honours in Organic Chemistry.

K. S. Wise, Second-Class Honours in Physiology; Third-Class Honours in Organic Chemistry.

Pass List.

Entire Examination; First Division.—J. G. Atkinson, S. M. Lawrence, W. C. Pickering, A. H. Pinder, H. W. Wilson. *Second Division.*—T. Bates, H. Finzel, S. M. Hebblethwaite, C. R. Keed, E. G. D. Milsom, E. F. Travers, A. D. White.

Excluding Physiology; First Division—J. M. Plews. *Second Division.*—C. N. Davis.

Physiology only; Second Division.—W. C. F. Harland, H. B. Hill, A. R. Neligan.

Conjoint Board.

Chemistry.—P. H. G. Gosse, A. C. Wilson.

Practical Pharmacy.—D. E. S. Davies, A. M. A. James, H. F. Webb-Bowen, H. D. H. Willis-Bund.

Anatomy and Physiology.—R. A. Fuller, S. B. Hambling, G. D. Watkins, M. Herzheim, J. Morris, S. C. Foster (approved in Physiology, four years' regulations).

The following have completed the examinations for M.R.C.S., L.R.C.P.:—F. H. Noke, F. R. Carrol, H. B. Butler, J. F. H. Dally, W. T. D. Mart, W. K. Parbury, H. L. P. Hulbert, H. H. Weir, W. G. Paget, R. T. Cooke, E. G. Smith, J. F. Robertson, E. F. Crabtree, H. Wreford, L. Galsworthy, H. Pritchard, M. B. Scott, W. J. G. Johnson, D. C. O'C. Finigan, E. C. Williams, H. H. Raw, T. C. Neville, J. J. S. Scrase, W. C. B. Smith, C. L. C. Owen.

UNIVERSITY OF DURHAM.

Elementary Anatomy and Biology, Chemistry, and Physics.—R. J. Douglas (Second-Class Honours).

Chemistry and Physics.—R. Bigg, M.R.C.S., L.R.C.P.; J. G. Gibb.

Anatomy, Physiology, and Materia Medica.—J. A. Bell, L. M. Rosten.

The degrees of M.B., B.S., have been conferred upon E. G. Klump, M.R.C.S., L.R.C.P., and R. Thorne-Thorne, M.R.C.S., L.R.C.P.

R. H. Vincent, M.B., B.S., has taken the degree of M.D.

Appointments.

BROWN, T. WARREN, M.R.C.S., L.R.C.P., appointed Surgeon to the s.s. "Java" (P. & O.).

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CATHCART, G. E., M.R.C.S., L.R.C.P., appointed a Civil Surgeon to the South African Field Force.

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CROSS, ERNEST W., M.R.C.S., L.R.C.P., appointed Medical Officer of Infant Orphan Asylum, Wanstead.

* * *

DUIGAN, V. J., M.R.C.S., L.R.C.P., appointed Junior House Surgeon to the Herefordshire County Hospital.

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HIRST, W. C., appointed House Physician to the Bradford Infirmary.

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RUMBOLL, C. F., M.D., B.S., appointed a Justice of the Peace for the County of Wilts.

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THORNLEY, R. L., M.B.(Lond.), appointed House Surgeon to the Dreadnought Hospital, Greenwich.

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WOOD, W. V., M.R.C.S., L.R.C.P., appointed House Surgeon to the Birmingham General Hospital.

New Addresses.

CRACE-CALVERT, G. A., Vale of Clwyd Sanatorium, Llanbedr Hall, near Ruthin, N. Wales.

KEMP, J. H., Tararna, Avenue Road, St. Albans.

MOBERLEY, SYDNEY C. H., Winslow, Bucks.

PATERSON, H. J., 9, Upper Wimpole Street, W.

SAUNDERS, ALLAN, Hampton Court.

YOUNG, T., Morthoe, N. Devon.

Birth.

FARNCOMBE.—On October 17th, at Bishopstone, Harborne, Birmingham, the wife of W. T. Farncombe, M.D., M.R.C.S. of a son.

Marriage.

MAXWELL—SAUNDERS.—At the Cathedral, Hong Kong, on 9th October, James Laidlaw Maxwell, M.D., B.S.Lond., Medical Missionary (E.P.M.), Formosa, to Millicent Bertha Saunders, daughter of the late Leslie Seymour Saunders, Esq., Bengal Civil Service.